TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ashley Ferguson FNP-C

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-17-0258-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 29, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to Medicare guidelines, in which we have provided for your review, in order to bill CPT 99204, the provider must meet 2 of the 3 components. When reviewing the medical notes, which we have provided, it can clearly be seen that more than 2 components were covered."

Amount in Dispute: $252.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of an acknowledgement of receipt of the medical fee dispute resolution on October 7, 2016. Texas Administrative Code §133.307 (d) (1) states, "Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." As no response was received this dispute will be reviewed based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 6, 2016	99204	$252.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 15 – (150) Payer deems the information submitted does not support this level of service
   - P1 – (P12) Workers' compensation jurisdictional fee schedule adjustment
   - BL – This bill is a reconsideration of a previously reviewed bill, allowance amounts do not reflect previous payments

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for professional medical services rendered on April 6, 2016 in the amount of $252.00.

   The insurance carrier denied disputed services with claim adjustment reason code 150 – "Payer deems the information submitted does not support the level of service."

   28 Texas Administrative Code §134.203 (b) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

The submitted code in dispute is 99204 – "Office or other outpatient visit for the evaluation and management of a new patient, which **requires these 3 key components**: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family."

Review of the submitted medical documentation with "date of encounter, April 6, 2016," finds the following:

Required Element	Present within Submitted Documentation Findings	Requirement of Code Met
Comprehensive History	History of present illness: Location, severity, timing, quality, associated signs and symptoms = Extended Review of systems: Constitutional, ears, nose mouth, throat, card/vasc, resp, GI, musculo, neuro, psych, endo, hem/lymph = Complete Past medial, family, social history, areas: Past Medical History, Family history, Social history = Complete	Yes
Comprehensive Examination	Body Areas: Back, including spine, seven extremities Organ systems: constitutional, eyes, cardiovascular, resp, GI, musculo, skin, neuro, psych = Comprehensive	Yes
Moderate complexity medical decision making	Number of Diagnoses or Treatment options points = 4 Amount and/or Complexity of Data Reviewed = 1	No Straightforward

	Risk of Significant Complications, Morbidity, and/or Mortality: Two or more self-limited or minor problems, x-rays, sling, physical therapy = Low	
Forty-five minutes face to face with the patient/and or family	No documentation found to indicate face to face time	n/a

The requestor states, "…in order to bill CPT 99204, the provider must meet 2 of the 3 components." In the narrative description of the CPT Code the following is found, "which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity." Therefore, the requestor's statement is not supported.

Based on the above, the carrier's denial is supported. No additional payment is recommended.

2. The Division finds no additional payment is due as the requirements of Rule 134.203 (b) were not met.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		November 17, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.